Filed for intro on 01/14/2003

HOUSE BILL 24
By Turner M

AN ACT to amend and repeal portions of Tennessee Code Annotated, Title 56, Chapter 32, Part 2, and to enact the "Health Maintenance Organizations Accountability Act".

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF TENNESSEE:

SECTION 1. The title of this act is, and may be cited as, the "Health Maintenance Organizations Accountability Act".

SECTION 2. It is the intention of the general assembly to:

(1) Impose a duty of ordinary care on health maintenance organizations in their health care treatment decision-making processes.

(2) Create a two-tiered system of review for a health maintenance organization's denial of, delay in, or failure to pay for health care services: a patient may seek internal review by the health maintenance organizations with an option to appeal to an external independent medical review board.

(3) Impose liability on a health maintenance organization for failure to exercise ordinary care by creating a cause of action that is limited to patients who have been denied health care services, have experienced substantial harm, and have exhausted the "Review of Adverse Determinations" process (internal and external), but bars punitive damages when a health maintenance organization adheres to the decision of the independent medical review board.

SECTION 3. Tennessee Code Annotated, Section 56-32-202(4), is amended by inserting the language "and a health care plan, including covered dependents" immediately after the word "organization" and before the punctuation ";".

SECTION 4. Tennessee Code Annotated, Section 56-32-202(7), is amended by deleting the punctuation ";" at the end of the item and substituting instead the following:

Additionally, for the purposes of Sections 8 through 11, inclusive of this act, organization includes health care plans and other managed entities;

SECTION 5. Tennessee Code Annotated, Section 56-32-202, is amended by adding the following as new items to be appropriately designated:

( ) "Health care plan" means any plan whereby a person undertakes to provide, arrange for, pay for, or reimburse any part of the cost of any health care services;

( ) "Health care treatment decision" means a decision that affects the quality of the diagnosis, care, or treatment provided to the plan's enrollees, whether medical services are actually provided by the health care plan or not;

( ) "Health insurance carrier" means an authorized insurance company that issues policies of accident or sickness insurance or both;

( ) "Managed care entity" means a person that delivers, administers, or assumes risk for health care services with systems or techniques to control or influence the quality, accessibility, utilization, or costs and prices of such services to a defined enrollee population, but does not include an employer purchasing coverage or acting on behalf of its employees or the employees of one or more subsidiaries or affiliated corporation of the employer or a licensed pharmacy;

( ) "Medically necessary" means the standard for health care services as determined by providers in accordance with the prevailing practices and standards of the medical profession and community in light of conditions at the time of treatment;

( ) "Utilization review" means a system based on established clinical criteria for reviewing the appropriate and efficient allocation of health care services given or proposed to be given to a patient or group of patients;

( ) "Utilization review organization" means any person that undertakes to provide or arrange for utilization review, as defined in Section 9 of this act.

SECTION 6. Tennessee Code Annotated, Section 56-32-210, is amended by deleting subdivision (a)(2)(A) and by substituting instead the following:

(2)(A) "Grievance" means a written complaint submitted by or on behalf of a covered person regarding matters pertaining to the terms and conditions of the contractual relationship between a covered person and the health maintenance organization.

SECTION 7. Tennessee Code Annotated, Section 56-32-210(b)(4), is amended by deleting subitems (A) and (B) and by substituting instead the following:

(4)

(A) A description of the procedures of such grievance system;

(B) The total number of grievances handled through such grievance system and a compilation of causes underlying the grievances filed; and

SECTION 8. Tennessee Code Annotated, Section 56-32-213, is amended by adding the following as new subsections:

(f) A health insurance carrier, health maintenance organization, or other managed care entity for a health care plan may not remove from or refuse to renew a physician with its health care plan for:

(1) advocating on behalf of an enrollee for medically necessary health care;

(2) filing either a "request for reconsideration" defined in Section 56-32-227(a) or a "request for appeal" defined in Section 56-32-227(b); or

(3) filing a cross-claim in a medical malpractice claim.

(g) A health insurance carrier, health maintenance organization, or other managed care entity for a health care plan may not remove from or refuse to renew an enrollee with its health care plan for:

(1) filing either a "request for reconsideration" defined in Section 56-32-227(a) or a "request for appeal" defined in Section 56-32-227(b); or

(2) threatening to file or actually filing a cause of action defined in Sections 56-32-237(a) and (b).

SECTION 9. Tennessee Code Annotated, Section 56-32-227, is amended by deleting the existing section in its entirety and by substituting instead the following:

(a) For the purposes of this section:

(1) "Adverse Determination":

(A) An "adverse determination" means:

(i) a utilization review decision or determination;

(ii) by a health insurance carrier, health maintenance organization, other managed care entity for a health care plan, or utilization review organization, or its employee, agent, ostensible agent, or representatives who are acting on its behalf and over whom it has the right to exercise influence or control, or has actually exercised influence or control;

(iii) that a proposed or delivered health care service was not:

(aa) medically necessary, and

(bb) may result in noncoverage of the health care service.

(B) There is no "adverse determination" if:

(i) the health insurance carrier, health maintenance organization, other managed care entity for a health care plan, or utilization review organization and the provider on behalf of the patient reach an agreement on the proposed or delivered health care services, or

(ii) the decision relates to a subscriber's status as an enrollee.

(2) "Emergency Reconsideration" means a request for reconsideration that:

(A) requires an expedited review due to medical or health circumstances; and

(B) meets the standards for emergency reconsideration set forth by the commissioner.

(3) "Internal Review Committee" (IRC) means the entity established by a health insurance carrier, health maintenance organization, other managed care entity for a health care plan, or utilization review organization to review requests for reconsiderations in compliance with the requirements defined in this section and the standards set forth by the commissioner.

(4) "Reconsideration Decision" means a final decision by an internal review committee regarding an adverse determination. A "reconsideration decision" arises from a request for reconsideration filed

with the internal review committee under its internal reconsideration process defined in this subsection regarding an adverse determination.

(5) "Request for Reconsideration" means a written request for reconsideration of an adverse determination, or a denial of, delay in, or failure to pay for health services, that is filed with an internal review committee by a patient or a provider on behalf of a patient.

(6) "Utilization Review Plan":

(A) A "utilization review plan" means:

(i) a description of the standard governing utilization review activities;

(ii) performed by a health insurance carrier, health maintenance organization, other managed care entity for a health care plan, or utilization review organization, or its employee, agent, ostensible agent, or representatives who are acting on its behalf and over whom it has the right to exercise influence or control, or has actually exercised influence or control.

(B) A "utilization review plan" must comply with standards for utilization review plans set forth by the commissioner.

(b) Each health insurance carrier, health maintenance organization, other managed care entity for a health care plan, or utilization review organization must establish:

(1) An internal review committee (IRC) whose composition, certification, licensure, and reporting requirements comply with the IRC standards set forth by the commissioner;

(2) An internal reconsideration process that:

(A) provides for IRC review of requests for reconsideration that request reconsideration of an adverse determination, or a denial of, delay in, or failure to pay for health care services;

(B) adheres to an approved utilization review plan; and

(C) provides written notification of the IRC's reconsideration decision to the requesting enrollee within thirty (30) days of filing, except when the precipitating events meet the standards for an emergency reconsideration set forth by the commissioner, in which case the IRC must provide written notification of its reconsideration decision within twenty-four (24) hours of filing;

(3) A review of the internal reconsideration process that:

(A) monitors the activities and determinations of the IRC; and

(B) complies with the standards set forth by the commissioner.

(c) Each health insurance carrier, health maintenance organization, other managed care entity for a health care plan, or utilization review organization must notify all of its enrollees in writing of its internal reconsideration process at enrollment and biannually thereafter according to the standards for notification set forth by the commissioner.

(d)

(1) For the purposes of this subsection:

(A) "Appeal Decision" means a final decision by the IMRB regarding a review of a reconsideration decision. The "appeal decision" arises from a request for appeal under the external appeals process defined in this subsection.

(B) "Independent Medical Review Board" (IMRB) means the entity or health care experts appointed by the commissioner to decide requests

for appeal in compliance with the requirements set forth in this subsection.

(C) "Request for Appeal" means a written request for a review of a reconsideration decision that is filed with the IMRB by a patient or a provider on behalf of a patient.

(2) The commissioner shall establish an independent medical review board (IMRB) that:

(A) is composed of health care experts in all specialties and areas of medical practice in compliance with the IMRB standards set forth by the commissioner;

(B) meets certification, licensure, reporting, and conflict of interest requirements set forth by the commissioner;

(C) reviews as an entity or in part, as deemed appropriate by the commissioner after the filing of all requests for appeal protesting a reconsideration decision; and

(D) provides written notification of its appeal decision within five (5) days of filing.

(3) The health insurance carrier, health maintenance organization, other managed care entity for a health care plan, or utilization review organization

(A) whose health care treatment decision; or

(B) whose employees, agents, ostensible agents, or representatives who are acting on its behalf and over whom it has the right to exercise influence or control, or over whom it has actually exercised influence or control, concerning a health care treatment decision;

that has been protested by a filed request for appeal shall pay the cost of applying for and obtaining the IMRB's review of the request for appeal.

(4) The appeal decision is not binding on the health insurance carrier, health maintenance organization, other managed care entity for a health care plan, or utilization review organization, or its employee, agent, ostensible agent, or representatives who are acting on its behalf and over whom it has the right to exercise influence or control, or has actually exercised influence or control. If however, the health insurance carrier, health maintenance organization, other managed care entity for a health care plan, or utilization review organization does comply with the appeal decision, damages for a cause of action alleging a failure to exercise ordinary care defined in Sections 56-32-234 and 56-32-239(a) and (b) will be limited as defined in Section 56-32-240(c).

SECTION 10. Tennessee Code Annotated, Title 56, Chapter 32, Part 2, is amended by adding the following as a new section:

56-32-239

(a) For the purposes of this section, "ordinary care" means the degree of care that a health insurance carrier, health maintenance organization, or other managed care entity for a health care plan of ordinary prudence would use under the same or similar circumstances. For a person who is an employee, agent, ostensible agent, or representative of a health insurance carrier, health maintenance organization, or other managed care entity for a health care plan, "ordinary care" means the degree of care that a person of ordinary prudence in the same profession, specialty, or area of practice would use in the same or similar circumstances.

(b) A health insurance carrier, health maintenance organization, or other managed care entity for a health care plan has the duty to exercise ordinary care when making health care treatment decisions.

(c) The duty of ordinary care extends to health care treatment decisions made by a health insurance carrier, health maintenance organization, or other managed care entity for a health care plan or its:

(1) employees;

(2) agents;

(3) ostensible agents; or

(4) representatives who are acting on its behalf and over whom it has the right to exercise influence or control, or has actually exercised influence or control.

SECTION 11. Tennessee Code Annotated, Title 56, Chapter 32, Part 2, is amended by adding the following as a new section:

56-32-240

(a)

(1) A health insurance carrier, health maintenance organization, or other managed care entity for a health care plan is liable for damages for substantial harm to an enrollee proximately caused by its failure to exercise ordinary care.

(2) Liability for failure to exercise a duty of ordinary care extends to health care treatment decisions made by a health insurance carrier, health maintenance organization, or other managed care entity for a health care plan or its:

(A) employees;

(B) agents;

(C) ostensible agents; or

(D) representatives who are acting on its behalf and over whom it has the right to exercise influence or control, or has actually exercised influence or control.

(b)

(1) It is a defense to any action filed against a health insurance carrier, health maintenance organization, or other managed care entity for a health care plan that:

(A) neither the health insurance carrier, health maintenance organization, or other managed care entity for a health care plan, nor any employee, agent, ostensible agent, or representative for whose conduct the health insurance carrier, health maintenance organization, or other managed care entity for a health care plan alleged to be liable under subsection (a) did control, influence, or participate in the health care treatment decision;

(B) the health insurance carrier, health maintenance organization, or other managed care entity for a health care plan did not deny or delay health care services or payment in the health care treatment decision;

(C) the injured enrollee failed to exhaust the procedures in the "review of adverse determinations" defined in Sections 56-32-227(a) and (b); or

(D) that greater than one (1) year has elapsed since the date the injured enrollee filed a request for appeal defined in Section 56-32-227(b).

(2) The standards set forth in subsection (a) do not create an obligation for a health insurance carrier, health maintenance organization, or other managed care entity for a health care plan to provide to an enrollee any health care service that is not covered by the health care plan.

(3) This section does not create liability for an employer, an employer group purchasing organization, or a licensed pharmacy that:

(A) purchases coverage, or

(B) acts on behalf of its employees.

(4) This section does not create liability on the part of the independent medical review board (IMRB) defined in Section 56-32-227(b). No liability shall lie against any IMRB member exercising due care for any health care treatment decision made in the performance of the duty, function, or activity of the IMRB.

(5) A health insurance carrier, health maintenance organization, or other managed care entity for a health care plan are barred from entering into a contract with a physician, hospital, other provider, or pharmaceutical company that includes an indemnification or hold harmless clause for the acts or conduct of the health insurance carrier, health maintenance organization, or other managed care entity for a health care plan. Any such indemnification or hold harmless clause in an existing contract is hereby declared void.

(6) Nothing in any law of this state prohibiting a health insurance carrier, health maintenance organization, or other managed care entity for a health care plan from practicing medicine or being licensed to practice medicine may be asserted as a defense by such health insurance carrier, health maintenance organization, or other managed care entity for a health care plan in an action brought against it pursuant to this section or any other law.

(7) In an action against a health insurance carrier, health maintenance organization, or other managed care entity for a health care plan, a finding that a physician or other provider is an employee, agent, ostensible agent, or representative of such health insurance carrier, health maintenance organization, or other managed care entity for a health care plan will not be based solely on proof that such person's name appears in a listing of approved physicians or providers make available to insureds or enrollees under a health care plan.

(8) This section does not apply to workers' compensation insurance coverage.

(c) In an action against a health insurance carrier, health maintenance organization, or other managed care entity for a health care plan pursuant to this section in which liability is admitted or established, the damages awarded include all damages listed in Section 29-26-119 for medical malpractice, except that no punitive damages are available when:

(1) No adverse determination has been made by the health insurance carrier, health maintenance organization, or other managed care entity for a health care plan, as defined in Section 56-32-227(a); or

(2) The health insurance carrier, health maintenance organization, or other managed care entity for a health care plan:

(A) complies with the appeal decision of the IMRB, as defined in Section 56-32-227(b), and

(B) actually provides the recommended health care service.

SECTION 12. The commissioner is authorized to promulgate rules and regulations to effectuate the purposes of this act. All such rules and regulations shall be promulgated in accordance with the provisions of Tennessee Code Annotated, Title 4, Chapter 5.

SECTION 13. If any provision of this act or the application thereof to any person or circumstance is held invalid, such invalidity shall not affect other provisions or applications of the act which can be given effect without the invalid provision or application, and to that end the provisions of this act are declared to be severable.

SECTION 14. For the purposes of rulemaking this act shall take effect on becoming a law and for all other purposes it shall take effect on January 1, 2003, the public welfare requiring it.